

## **The Public Option: From Hacker to Biden**

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### **Introduction**

Presidential candidate Joe Biden's proposal for a public option is likely to be a major topic in the upcoming presidential debate. While the proposal certainly isn't the first of its kind, in light of the recent COVID-19 pandemic it is especially significant due to the rapid increase in the number of people without insurance (Stolberg, 2020). To better understand the arguments for this proposal and other public option or opt out proposals, we discuss the following: (1) Jacob Hacker's original ideas and arguments for a public option and why it was left out of the ACA, (2) A review of the cost and coverage impacts of various public option reforms conducted by the Urban Institute, (3) An examination of the only state-based public option passed by Washington State, (4) The current version of Biden's public option, and (5) Final thoughts.

### **Jacob Hacker's Public Option**

Jacob Hacker was one of the earliest and most vocal proponents of the Public Option, putting forth a Medicare-like public insurance plan in 2003 and then Medicare Part E (for "Everyone") in 2017. Throughout the years, his papers and proposals present three key reasons for why a public plan should be offered alongside the existing private sector, as well as a potential path to implementation for the public option. Hacker posited that public insurance has several key strengths that allow it to (1) control short- and long-term costs, (2) spearhead quality improvements, and (3) serve as a benchmark against which private plans can compete (Hacker, 2008). A hybrid health care system in both the public and private sector would provide a means by which those with and without insurance would have greater choices of plans that could provide good quality care at an affordable price.

Hacker's first argument centered on several cost-control advantages that public plans have over private plans. First, regarding administrative costs, public systems can be much more efficient at managing administrative duties than private plans. For example, Medicare spends less than 2% of total expenditure on overhead costs, while Medicare Advantage spends nearly 11% (Congressional Budget Office, 2006). Second, in bargaining leverage, large government-run plans have tremendous bargaining potential against hospitals, providers, and pharmaceutical companies. Although Medicare does not allow for drug negotiations, the Veterans Health Administration (VHA) and Medicaid have negotiated drug prices, on average, 49% less than the average wholesale cost. Third, a public plan would not be burdened by profit margins and investor interests. As markets have become increasingly concentrated, prices have risen without commensurate quality improvements (Schwartz, 2020). Hospitals have little incentive to control costs as higher costs can easily be pushed onto patients, resulting in higher profit. Medicare is what encourages hospitals to improve efficiency and control costs. Finally, public plans have demonstrated long term cost controls: since Medicare payment controls were implemented in the 1980s, Medicare spending has grown much more slowly than in the past (White, 2008).

Hacker's second argument emphasized the quality improvements in private plans that could come about as a result of a two-tier system. By looking at the VHA and Medicare, he drew

examples of how their electronic records systems and quality measurements/monitoring not only improved accountability within the systems, but were also adapted by private insurers. Additionally, with large databases of patient data, the public option can collect and analyze extensive outcomes data. New methods of providing and paying for care and using market power to promote quality could lead to a quality revolution.

Hacker's final argument highlighted the public option as a standard against which private plans compete. Private plans have historically emulated Medicare's prospective payment system for hospitals, physicians, and nursing homes. Having the public plan would help rein in costs from monopolies in certain areas and focus on driving value. The key would be to allow Americans to choose for themselves whether they want the stability and social protection of the public plan or the flexibility and private innovation within private plans. This hybrid system could improve the quality of both groups of health care systems, while simultaneously pushing affordability.

Ultimately, in 2017, Hacker introduced Medicare Part E (for "Everyone") which presented one potential implementation of a public option. Medicare Part E would include the benefits under Medicare Part A, B, and D and would be available to everyone. Those with private insurance would be allowed to keep it, and those who needed insurance would be automatically enrolled. Part E would also have a requirement for employers similar to that of the ACA: employers would either have to make wage-based contributions to Medicare Part E if they did not provide insurance ("pay") or provide qualified insurance themselves ("play"). To fund the program in addition to employer contributions, individuals would need to pay a small income-based premium that has been estimated to be between \$250-\$300 for those at the highest level of earnings (Hacker, 2017). While the proposal acknowledges that Part E is but one way of moving the United States towards universal coverage, Hacker asserts that it is currently the best way of overcoming the political and financial barriers to affordable health care for all.

While Hacker's plan was well-received by many Democrats, the public option has had a turbulent past in Congress, with particular difficulty in the Senate (Halpin & Harbage, 2010). Although House committees had relative success in passing health care reform bills that included public options, similar proposals were unable to pass the Senate. Two such proposals were presented by Sen. Rockefeller (D-West Virginia) and Sen. Schumer (D-New York), respectively, and were firmly rejected by the Finance Committee. The public option finally came to a halt when Sen. Lieberman (I-Connecticut) threatened a filibuster against any bill with a public option (Halpin & Harbage, 2010). Despite negotiations, Sen. Lieberman remained steadfast and the public option was dropped. Without his vote, there was no path for the public option to move forward. Ultimately, the final reconciliation bill between the Senate and House was signed and passed in 2010 by President Obama with no mention of the public option.

### **The Urban Institute's Impact Analysis**

A March 2020 report from the Urban Institute assessed eight different potential implementations of a public option as well as their respective financial impacts. The first three reforms look at the impact of a public option if it were to only be implemented in the private, nongroup insurance market. Overall, in these three scenarios, the impacts on federal spending, household spending, and the number of uninsured were minimal. In the base case option in which Medicare rates were paid to hospitals and providers, the number of uninsured would only fall by 230,000. The report's subsequent three reforms considered the impact of a public option

implemented in both the nongroup and employer markets. In this base case scenario, the number of uninsured would fall by 1.7 million and household health care spending would fall by \$76.3 billion (14%). The decrease in the number of uninsured is much more substantial and it would result in larger decreases in premiums than if only the nongroup insurance market were impacted. The report's final two reforms consider capping payment rates for both employer and nongroup prices rather than implementing a new public plan. In a scenario where rates would be capped modestly above Medicare, the uninsured would decrease by 1.6 million and household spending would decrease by \$109.2 billion (20%). The tremendous drop in household spending is due to the fact that this plan would impact all employers and their workers. Since all individuals achieve savings, there are large decreases in household, employer, and federal spending.

Based on this analysis, the Urban Institute was able to conclude that any form of public option in both the nongroup and employer markets, whether it be a government-run plan or capping existing payment rates, will significantly reduce the number of uninsured individuals, decrease premiums, and decrease household and employer spending (Blumberg et al., 2020a, Blumberg et al., 2020b). Their conclusion was relatively straightforward: capping payment rates for everyone will decrease overall household spending; the inclusion of the employer insurance market will result in more substantial change than with just the nongroup market; and increasing the payment rate will decrease the effect of the reform because premiums will be higher.

Of course, the Urban Institute acknowledged that the analysis certainly has its limitations. Some of the necessary data to make exact calculations on the nongroup insurance market was not publicly available so information was taken from proxy sources. Additionally, the researchers were unable to predict how providers would necessarily react to large drops in revenue, and how any disruptions in the delivery system would impact access or quality of care. They also recognized that all of these reforms would result in substantial changes in other areas of life such as employment and wages that could not be easily measured or taken into consideration. Despite the limitations, the analysis gives us a credible estimate of the potential impact of each reform. The Urban Institute report provides insight into the complicated nature of any public option plan and how even a small variation in policy can dramatically affect the impact.

### **Washington State's "Public Option"**

While Congress has struggled to pass a plan with a complete public option, Governor Jay Inslee of Washington State has touted his state's new plan as the nation's first public option health plan. Cascade Care came about as a result of dramatically rising premiums on the individual market, as well as the long-standing issue of "bare counties" that have little to no insurer participation (Matthew & Radnofsky, 2017). In 2019, there were 14 counties that only had 1 insurer, but by 2021, there will be at least two insurers available in every county within Washington, a substantial improvement from before (Sparer, 2020). The public option will increase insurer competition and help cover areas that lack insurer participation.

However, the Cascade Care public option is not a traditional public option in that the state itself is not providing a plan for consumers to purchase. Instead, the state is contracting with private insurance companies to provide state-sponsored "public option" plans that offer standardized benefits, have cost-sharing at each metal tier, and cap reimbursement rates (Capretta, 2020). Rather than go through the difficulty of creating their own insurance plan, the state has opted to provide what are essentially privately delivered and publicly controlled

insurance plans. The legislature has stated that the goal of Cascade Care is to achieve the benefit of the public option, but bypass the financial, administrative, and political barriers to creating a state-run plan (Capretta, 2020).

The state-sponsored public option plans cap reimbursement rates for providers and hospitals at 160% of Medicare, much higher than was originally proposed by the legislature (Capretta, 2020). The initial proposal capped reimbursement rates at 100% of Medicare in an attempt to curb costs, but this cap was later raised due to heavy pushback from providers and hospitals. Previously, the State Exchange had calculated that private insurance reimbursement rates averaged around 174% of Medicare (Kliff, 2019). Therefore, the state-sponsored plans will not have as large of an impact as predicted due to the cap increase, with the state estimating only between a 5-10 percent drop in premiums (Sparer, 2020). Another drawback of Cascade Care is that provider and hospital participation in the state-sponsored plans is not mandatory, which could result in a smaller network of participating providers than expected (Capretta, 2020). With only moderate decreases in premiums and a potentially small provider participation rate, the impact of these state-sponsored plans may not be overwhelmingly positive. While it is clear that this public option is a tremendous step forward in pushing affordable and high quality health care, the drawbacks of the plan only highlight the overwhelming influence and power that providers and hospitals exert on public policy.

### **Biden's Public Option in Medicare**

In July of this year, former Vice President Joe Biden and Senator Bernie Sanders (D-VT) released the Biden-Sanders Unity Task Force Recommendations (2020) that combined policy ideas from both teams on issues of health care, the environment, criminal justice and more. The health care recommendation, which appears to be influenced by Jacob Hacker, presents a proposal for a public option to be made available to all Americans. Of course, the recommendations simply outline Biden's agenda should he win the November election and do not delve into the specifics of the option. However, the task force does highlight some high level ideas for the public option. The public option would be made available for all Americans regardless of their current insurance status, and the program will be administered like traditional Medicare. Although it would not be mandatory, the lowest income Americans who currently are uninsured would automatically be enrolled in the program at no cost. The income bracket included within this group was not clearly specified. Additionally, the recommendation specifies that the public option would be available with no premium for individuals who should qualify for Medicaid in states that have not expanded Medicaid. Notably, while this covers approximately 4.8 million Americans in non-expansion states, it does not address the millions of uninsured Americans in expansion states. The success of this public option will come in the details, especially the issue of price and whether or not providers will agree to it.

### **Final Thoughts**

Americans on both the left and right agree that choice matters. The classic writings by Nobel Laureate Milton Friedman, *Free to Choose* (1990) and *Capitalism and Freedom* (1962), point out that choice is essential for the market to produce what individuals want in the most efficient way. Friedman also proposed a guaranteed income before Andrew Yang was even born. A guaranteed income would replace the bureaucracy of current government welfare programs by giving the people a choice in what they spend their money on in the market (Friedman, 1962).

Rather than a mix of welfare programs, everyone would receive a minimum choosing right on what they wanted to buy. This role of choice is now the current focus of the health care debate, particularly with regard to the public option. However, the provision of choice from the government does raise the question: Has the nanny state gone too far?

Undoubtedly, there may not be a one size fits all solution to our current health care situation. While Biden's public option moves us closer to universal coverage by providing a Medicare-like option, it is a nanny state solution, but ultimately still one worth considering. By taking lessons from international models of health care, such as Germany and Australia, the introduction of a public option can build a successful two-tier public-private system (Scheffler & Wang, 2020). As we continue to use the private insurance market for those under 65, Milton Friedman might have made the same suggestion of a public option today.

### **Authors' Note**

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